Missouri

Health Care Stabilization Fund

Feasibility Board

Data Call

Codebook

December, 2009

(Revised 2/11/2010)

HCSFFB Data Call Codebook

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The following additional materials can be accessed via the "HCSFFB Data Call" link on the Department's web site at:

http://insurance.mo.gov/private/medmalindex.htm

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The ISO Specialty Codes

A Visual Data Set Overview

A Chart of Data Set Variable Names

A Non-PDF Copy of Questionnaire (with Reconciliation Sheets)

Spreadsheet Templates of Data Set #s 1, 2, 3, & 4 plus the Reconciliations

A Frequently-Asked-Question & Updates page

Initial Contact Information

Please provide contact information, including your company's name, the name of the individual serving as your liaison with the Department for this data call, that person's job title, telephone number, email address and mailing address.

Email this initial contact information to statistics@insurance.mo.gov by December 21**, 2009**. Please include "HCSFFB Data Call" in the subject line.

Summary of HCSFFB Data Call

Background

Missouri's Health Care Stabilization Fund Feasibility Board ("the HCSFFB" or simply, "the Board") was created by the Missouri General Assembly as part of the package of tort and insurance reforms passed in 2005 and 2006 in response to the state's third medical malpractice crisis in recent decades. In 2006, the General Assembly created the HCSFFB to investigate the feasibility of establishing a stabilization fund in Missouri.

Scope of the Data Call

The provision governing the HCSFFB, Section 383.250, RSMo, provides that "[t]he board shall analyze medical malpractice insurance data collected by the department of insurance, financial institutions and professional registration under sections 383.105 and 383.106 and any other data the board deems necessary to its mission." While the Missouri Department of Insurance, Financial Institutions and Professional Registration ("DIFP" or "the Department") has made several attempts at promulgating regulations under these two sections, it is not clear when final regulations will be approved and data will be collected under them. With their statutory sunset date of December 31, 2010 fast approaching, the Board voted to have DIFP collect the data under whatever other appropriate authority it had available to it.

In so doing, the HCSFFB also approved an outline of the information to be collected through the data call. The focus will be on premium, loss and exposure information, collected by Missouri county and by health care provider specialty codes, as well as a number of other relevant "data categories" relating to the type and amount of coverage. Since DIFP's records indicate 1997 was the last year the state's medical malpractice insurance market experienced relatively stable profitability, the Board voted that the data call should start from that calendar year and proceed through the ensuing phases of the "insurance cycle" in Missouri, up to the present. For purposes of the data call, the Board also selected $300,000 as the attachment point for excess coverage under a hypothetical Missouri stabilization fund; at one points the data call will ask insurers to report "basic limits" case basis loss reserves, which will require them to report their actual reserves capped at this attachment point so that the Board can see what level of reserves a hypothetical fund would have experienced had it been in operation. DIFP will also do a similar calculation regarding basic limits direct indemnity losses paid using other information collected in the data call.

Information should be aggregated by the various provider specialty codes and counties, so that specialties in areas of the state with significant claims activity will be combined for reporting purposes. "Provider specialty" and "county" information will be used to see if different health care provider groups were affected differently in the different regions of the state during the last medical malpractice market downturn. These data will help the HCSFFB determine whether any future Missouri stabilization fund should be limited to specified medical specialties or geographic regions.

The DIFP Statistical Section has developed this Codebook, which defines the various data elements and data categories of the HCSFFB data call, as well as other key technical terms. DIFP encourages reporting insurers to review the Codebook and contact the staff of the Statistics Section if they have

any questions. **Data submissions from reporting insurers must conform to all specified reporting formats. Failure to do so may result in a rejected filing and necessitate a re-filing.**

Note: In requesting that the data be reported in a form that aggregates the data by categories such as Missouri county and health care provider specialty code, DIFP is in part tailoring the data to the specific needs of the HCSFFB; however, it is also helping to assure the confidentiality of the more sensitive aspects of the data, such as certain reserve data related to individual claims collected in Data Set #3. By combining individual claim information into larger aggregates, individual claim details will be obscured. **In addition, only industry-wide aggregates will be available to the public, and only when such data conforms to statistical tests designed to preserve confidentiality.**

Confidentiality Standards

The Department will take the following steps to protect confidential and proprietary aspects of data collected pursuant to the HCSFFB data call:

The Raw Data Will Be Confidential: The Department is conducting this data call under the "investigations" authority contained in Section 374.190, RSMo. Under a separate provision, Section 374.071, RSMo, the documents or other materials submitted by an insurer under a DIFP investigation are considered *confidential and not "public" records or open to disclosure*, except to the limited extent set forth in that section. Therefore, no raw, company-specific data collected through the data call will be made available to the HCSFFB's non-DIFP board members or to the public.

Preserving the confidentiality of personally identifying information: The data will not be released in a form that could reasonably reveal, either directly or indirectly in conjunction with other publicly available information, the identities of any parties involved in a malpractice action or claim, including any insurer. Aggregate data that conforms to generally accepted standards of minimizing disclosure risk ***will*** be made available to the public (see below).

Specific Aggregation Procedures: To help ensure that individual identities cannot be inferred from such data or information, no such data or information related to the data call will be released by the Department to the public except in conformity with the standards contained in federal Office of Management and Budget Statistical Policy Working Paper 22 (Second Version, 2005) as follows:

(a) Individual data cells will include a minimum of five observations;

(b) The sum of all but the three largest observations will be no less than sixty percent of the largest value, unless a greater percentage is selected by the director;

(c) No single observation will be permitted to be more than fifty percent of a cell total, unless a lower percentage is selected by the director; and,

(d) The value of any threshold percentages in subparagraphs (b) and (c) above will be selected by the director and will be kept confidential.

Department Employees: The DIFP employees processing the data will themselves be governed by and subject to discipline under DIFP Regulation 20 CSR 10-3.100, and, for purposes of this project, only those employees who have an actual need to handle the raw data gathered by this data call will be granted such access. Any DIFP employee who intentionally discloses to a nonemployee of the department any confidential information in violation of these confidentiality provisions will be subject to possible termination from employment.

Distribution to Insurers: At their last board meeting, the HCSFFB voted to have the Department make its post-analysis, industry-wide aggregated information available to insurers to the extent allowed by law, as a way of assisting said insurers in developing more accurate premium rates and reserves.

Computer Format of Insurer Responses to the Data Call

It has been the experience of DIFP's Statistics Section that the least troublesome format for an insurer's response to a data call is a Microsoft Excel or similar spreadsheet format. While DIFP can process a number of the more common alternatives (delimited text files, etc.,) a spreadsheet program manages key formatting issues more or less automatically, and is usually easier for both the reporting insurers and the end-users at DIFP. However, if this format presents a substantial compliance hurdle to the reporting insurer, DIFP will consider alternatives upon request. Please consider this issue and contact the Statistics Section by email if necessary at the earliest possible opportunity.

Responses can be sent to the Department via email or on computer media sent either through the mail or by delivery service. If the email option is used, please note that the DIFP email system has a 10 megabyte cap on the size of an individual email, based on the total size of the email message itself plus the size of any attachments; should the information exceed 10 megabytes, consider dividing the response into multiple emails, preferably by data year. Also, files may be compressed using the ZIP compression format; please do not employ any alternative compression programs. Emails should be sent to:

statistics@insurance.mo.gov

Alternatively, data may be sent via U.S. Mail or private delivery service. The Department can accept information on CDs, DVDs or USB drives, formatted to be read by PCs using Microsoft software. Security-conscious insurers may encrypt the files so long as the Department is given the means to de-crypt them. Please do not send storage media of a different type or format. Discs or USB drives can be mailed to:

HCSFFB Data Call
Statistics Section
P.O. 690
Jefferson City, MO 65102-0690

Please remember to include your company's responses to the HCSFFB Data Call Questionnaire (see page 27 of this Codebook) along with the rest of your response.

DIFP Web Site Information

The Department has posted several new pages on its web site devoted to this data call:

1) A PFD Version of this HCSFFB Data Call Codebook;
2) A Set of the ISO Specialty Codes;
3) A Visual Data Set Overview;
4) A Chart of Data Set Variable Names;
5) A Non-PDF Version of the HCSFFB Data Call Questionnaire (with Reconciliation Sheets);
6) A Spreadsheet with Templates for Data Set #s 1, 2, 3, & 4, plus the Reconciliations; and,
7) A FAQs page.

The Department plans to use the FAQ page to circulate any updates to the data call. Reporting insurers should consult this web page on a regular basis as they proceed with the insurer's response. DIFP will note the date of its last revisions at the top of this page. The web address that will link to the pages listed above is:

http://insurance.mo.gov/private/medmalindex.htm

Timeframe for Insurer Responses

We recognize that responding to the HCSFFB's requested data call will require a significant level of effort on the part of reporting insurers. We are making a presumption that all the companies that were writing medical malpractice insurance in Missouri during the period from January 1, 1997 until the present employed modern computer database technologies that will allow them to retrieve the requested information electronically. Please have your relevant personnel: 1) review this summary and the other materials in this Codebook; 2) check your systems for the various years covered by the data call (i.e., 1997 to 2008); and 3) send an email to DIFP's Statistics Section ***by December 21, 2009*** indicating whether and to what extent the data are available for each of the years in question. The date for completing and submitting final responses by insurers to this data call is ***February 28, 2010***.

Visual Representations of the Data Sets

The HCSFFB Data Call uses two methods of visually representing the information to be collected. One approach, used on the bottom of this page, orients the variable names in an "east-west " direction, wherein the column headings represent "variable names" and the rows below them represent the cells where data on the individual observations would be entered. This approach is also used on the spreadsheet templates for the data call and a one-page chart of data sets and their variable names, provided by the Department on its web site at:

http://insurance.mo.gov/private/medmalindex.htm

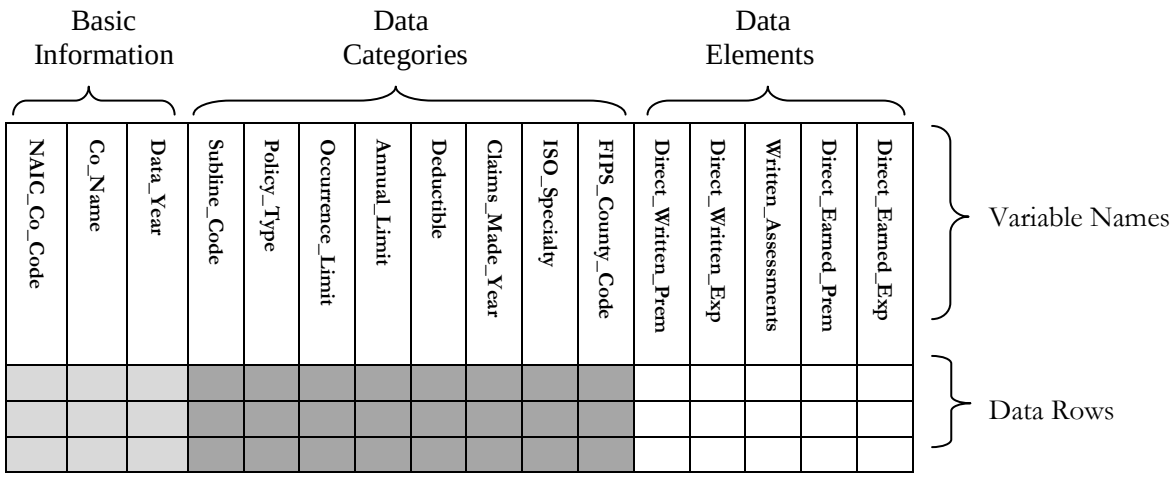
On the other hand, a "north-south" orientation of the variable names is used on the following page, because it makes reading the variable names a bit easier.

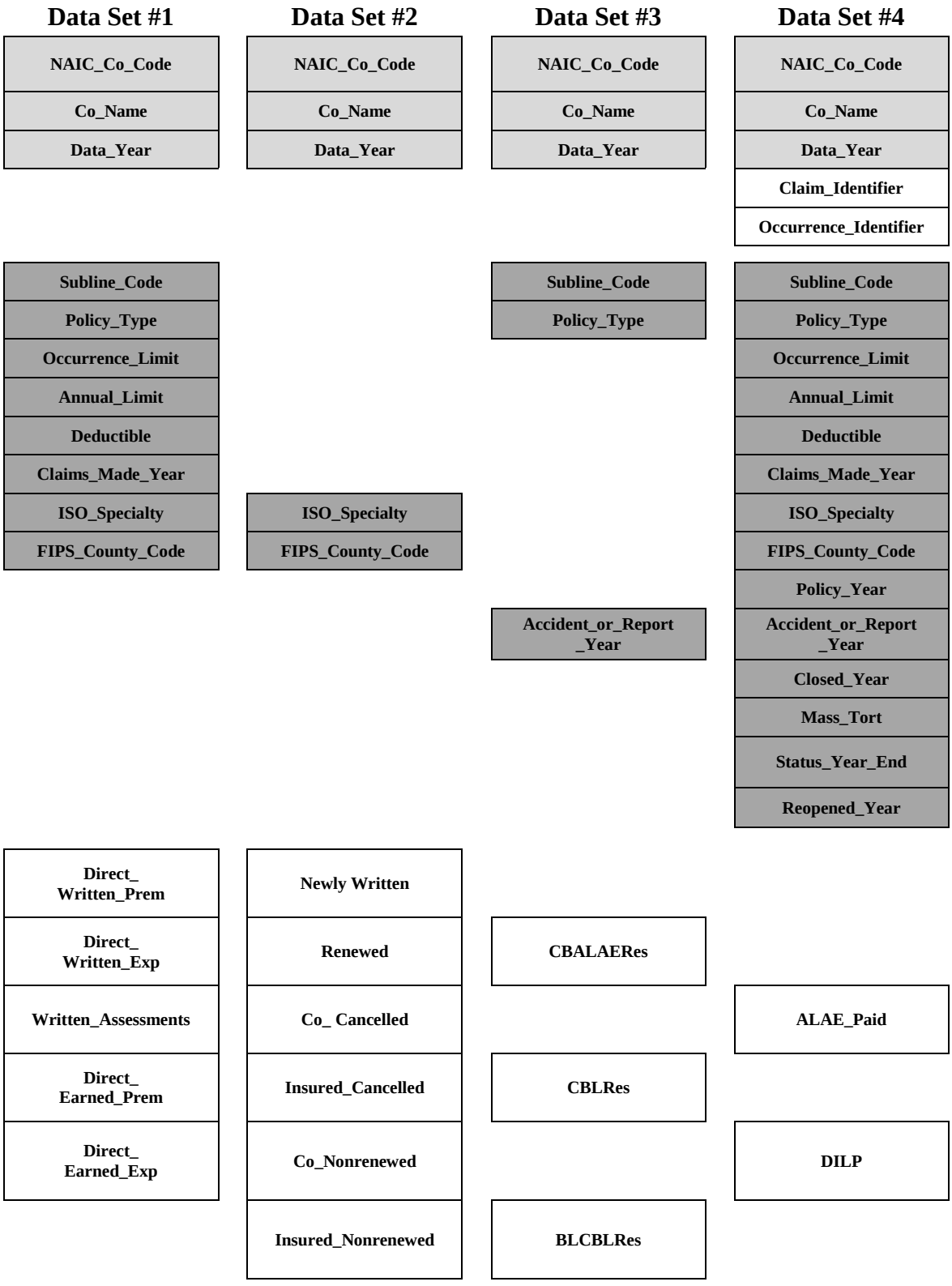
The data call is subdivided into four primary data sets, each representing distinct insurance company operations: Data Set #1 for premiums and exposures; Data Set #2 for underwriting information such as cancellations and nonrenewals; Data Set #3 for case basis indemnity and ALAE reserve postings; and, Data Set #4 for actual claim payments and ALAE payments.

Common features in the various data sets are shaded. Note that all the data sets require the reporting insurance company's 5-digit NAIC code number, name or other identifier (such as commonly used corporate initials), and the calendar or "data" year. Subsequent shaded columns represent "data categories," which include several items devoted to policy information, Insurance Services Office, Inc. (ISO) provider specialty code and Missouri County FIPS code. These "data categories" are in turn followed by "data elements" for the premium, exposure, policy and claim information being sought by the data call.

The chart below illustrates the various components of a data set. More complete definitions of the variable names are provided in later in the Codebook.

Example Data Call Matrix: Data Set #1: Premiums and Exposures





[Note: The "format" used for the variable names set forth above is designed to meet the requirements of that version of the SAS statistical package the Department will be using to analyze the data.]

General Definitions

This HCSFFB Data Call Codebook uses a number of terms defined below in this initial "General Definitions" section. Following those general definitions is a separate set of definitions regarding the various "variable names" used as column headings for the four Data Sets to identify the items of basic information, data categories and data elements to be reported under this data call.

Aggregation: Under Data Set #s1, 2 and 3, insurers report information on an aggregate basis that combines information on premiums and exposures that possess similar characteristics, such as the same accident date, report date, policy information, ISO provider specialty code, and so forth. The chief benefit of the aggregation process is to combine information in a manner which retains but also protects potentially sensitive information. The aggregation process is discussed in further detail beginning on page 15 of this Codebook. While the Department is only making public information from this data call which combines information across insurers, the "aggregation" process provides an added level of protection to key information even before it reaches the Department.

Allocated Loss Adjustment Expense (ALAE): Report ALAE in a manner consistent with the financial annual statement current for the data year in question, as defined under either the prior term "Allocated Loss Adjustment Expense" or the current term "Defense and Cost Containment." There is no requirement to reclassify ALAE for this report. Provide an explanation in the questionnaire of the basis of reporting ALAE in each of the data years. (See page 28 of this Codebook.)

Basic Limits Case Basis Loss Reserves: Reserves capped at a "basic limit" of $300,000. The Missouri Health Care Stabilization Fund Feasibility Board selected $300,000 as the attachment point for coverage under a hypothetical Missouri stabilization fund for purposes of analyzing the feasibility of a Missouri fund. The data element in this data call that requires a "basic limits" value is asking the reporting insurer to perform a calculation that caps individual case basis reserve amounts at $300,000. Because reserve data collected from insurers will be highly aggregated (e.g., statewide by policy type), the basic limits calculation will be necessary to determine the extent to which a Missouri stabilization fund might be called upon to pay a portion of individual claims.

Bulk Reserves: (See also "IBNR," below.) Under the instructions to the NAIC's Annual Statement Instructions for Schedule P:

> Bulk and IBNR reserves for losses and expenses are intended to include reserves for incurred but not reported claims, for reopened claims, for development on case reserves of reported claims, and for aggregate reserves on newly reported claims without specific case reserves. The Bulk and IBNR reserves are the actuarially determined reserves and are included in the losses unpaid and loss expenses unpaid reported in Schedule P, Parts 1 and 2." (*See page 233 of the Annual Statement Instructions.*)

The HCSFFB data call requests data in several instances on "reserves," but instructs the reporting insurer to *exclude* bulk and IBNR reserves. In these instances, the data call is requesting the case

reserve values established by the individual claims adjusters on a claim, but *not* any bulk or IBNR reserves set by the actuarial staff.

Case Basis Reserve: Report case basis reserves in a manner consistent with annual statement Schedule P. A case basis reserve is an estimate of the future indemnity or ALAE payments based on an analysis of the specific circumstances of the claim. A case basis reserve is an estimate of an unpaid amount and does not include partial payments already made.

Claim: For purposes of this data call, in situations involving a single insured and/or defendant and a single claimant concerning a single act of alleged medical malpractice, a "claim" has occurred whenever an insurer makes an initial indemnity or ALAE payment *or* posts an initial case basis indemnity or ALAE reserve under the policy. (For situations involving multiple insureds / defendants, multiple claimants, or other complex fact patterns, consult the *Discussion* section below.)

> *Discussion*: While a number of events other than those defined above are frequently referred to as "claims" in other contexts, for purposes of this data call, "claims" are those events meeting the simple definition set forth above. Claims should be reported under a consistent definition to ensure that such statistics as claims frequency and average claims cost are meaningful. While the simplified definition above will be relatively ease to apply to the vast majority of situations (such as those involving a single insured/defendant and a single claimant), a discussion of some of the more complicated situations is warranted, to further define what is to be counted as a "claim" and what *not* to be counted.
>
> While a policy will typically have a single policyholder, there may be any number of individual health care providers or institutions covered as insureds (specifically "named" or unnamed) under the policy. Claims should be included in data submissions where an initial indemnity, ALAE payment or a case reserve is posted on behalf of any of the multiple insureds, not merely the "named" insured or policyholders. Often, indemnity or ALAE payments or case reserve postings will be associated with formal legal actions against these insureds who have, as a result of the litigation, become "defendants," hence the use of the term "insureds/defendants" in the definition. However, please remember that a significant fraction of indemnity or ALAE payments or case reserve postings occur *outside* of formal litigation, and any initial payments or postings related to these informal situations are *also* considered instances of countable claims for purposes of this data call.
>
> In addition to indemnity or ALAE "payments," the other category constituting a "claim" is where the insurer's claims adjusters set aside case basis indemnity and/or ALAE reserves based on the specific facts of an individual case. Report *only* claims with *case basis* reserve postings; the posting of other types of reserves, specifically, "token reserves" and "bulk or IBNR reserves," by themselves, should *not* be counted as "claims" Token reserves are usually minimal dollar amounts posted - sometimes automatically by computer - to function as "placeholders" in an insurer's system to indicate the potential for future claims activity; they are often based on reports from insured health care providers as a way of establishing the "date" an event occurred for purposes of determining if coverage exists. Often, token reserves are removed and the file closed within a set period (say, twelve months) if no further activity on the matter - such as the receipt of a formal claim - takes place. While such token reserves should not be reported as claims under this

data call, *if* the underlying fact situation later changes such that an actual indemnity or ALAE payment is made or a case basis reserve (as determined by a claims adjuster) is posted, it should, then, be counted as a "claim" for the data year such payment or reserve posting takes place.

As in the case of token reserves, "bulk or IBNR reserves" should not, *by themselves*, be considered "reserve postings" that rise to the level of a "claim" to be added to a claim count under this data call. Only indemnity payments, ALAE payments or case reserves *posted by claims adjusters* should be counted as "claims," not token reserves or bulk or IBNR reserves set by the actuarial staff. "Bulk and IBNR reserves" are defined elsewhere in this codebook.

Multiple Insureds/Defendants and a Single Claimant: If multiple insureds or defendants *covered by the same reporting insurer* are named by a single claimant, then *each* named insured/defendant is a *separate* "claim" for purposes of claim counts under this data call. This definition of claim is similar to the one used in Missouri for the quarterly medical malpractice claim data reported pursuant to Section 383.105, RSMo. As such, the total number of claims reported to the Missouri Department of Insurance for a particular data year under this data call should correspond (approximately) to the total number of individual claim reports made to the Department in that same reporting year for purposes of Section 383.105, RSMo. However, a count of the number of "claims" under the definition of this data call is not *necessarily* equivalent to the count of claims reported on Supplement A to Schedule T to the Financial Annual Statement.

Multiple Claimants: Multiple individuals that are pursuing a claim for the same event or series of events should be treated as a *single* claim. For example, do not report a father and mother pursuing a claim in relation to an injured child as separate claims. Similarly, if a mother and child are injured during childbirth, treat the instance as a single claim.

Bottom Line: Whether you have multiple insureds/defendants or multiple claimants or both, the number of separate claims to report for this data call should equal the number of insured/defendant health care providers covered by the reporting insurer for the instance of alleged malpractice in question.

Mass Tort or Product Liability Litigation: During the data call's reporting period of from 1997 to 2008, there were a number of class action tort cases involving drugs, medical devices, specific medical procedures and the like. Mass tort cases frequently name individual health care providers as ancillary defendants, but actual indemnity payments on behalf of these insured providers are rare. Claims associated with mass tort or product liability cases should be identified as such in the appropriate "Miscellaneous" data category in Data Set # 4. Please see Item 10 the accompanying questionnaire regarding mass tort cases, on page 28.

Occurrence Policies: Alleged malpractice events spanning more than one policy period can generate a claim count in each policy period under an occurrence policy, even though they would likely generate only a single claim count under a claims-made policy. For occurrence policies, follow the general guidelines set forth above and count as a "claim" every situation under an occurrence policy where there is an initial indemnity or ALAE payment or initial case basis indemnity or ALAE reserve posting. Do not treat multiple malpractice events occurring in separate

policy periods as multiple claims *unless* separate policy limits apply to each such claim. Please make use of the accompanying questionnaire to clarify any departures from this standard

Claims Outside the Scope of the Policy's Coverage: For purposes of this data call, do *not* include situations which fall outside the scope of medical malpractice coverage. For example, exclude "bad faith" allegations by an insured provider against the reporting insurer. General liability claims brought by person not under the care of the provider should also be excluded. In general, if a claim results in activity on the medical malpractice line of the financial annual statement, the claim should be included in this data call.

Data Elements: This data call uses the terms "data elements" and "data categories" for two different aspects of the information being collected. The term "data elements" refers to the premium, loss and exposure information that is the focus of HCSFFB's analysis. By contrast, the "data categories" are the various ways in which the data call asks insurers to sort or group this premium, loss and exposure information.

Data Categories: In contrast to the basic premium, loss and exposure information represented by the "data elements" of this data call, the "data categories" are the various "bins" into which the data element information is to be sorted. The key data categories are health care provider ISO specialty code and Missouri county, as well as a number of categories regarding policy information, such as the type of coverage, the amount of coverage, the per-occurrence limit and the applicable deductible.

Data Year: The HCSFFB data call is seeking medical malpractice information back to calendar year 1997 – the last point in time when Missouri had relatively stable profitability (and, by implication, pricing) – through to and including 2008. Each calendar year can be considered a separate "data year" for purposes of analysis and therefore the "data year" is a key category of "basic information" into which the various data elements will need to be sorted under this HCSFFB data call. Often, the instructions for this data call will specify that the data be reported "through 12/31/yyyy," which means "from January 1 or thereafter in the data year in question through to and including December 31 of that same data year."

For each data year, including the initial data year of 1997, report

1. Claims that are open during the year;
2. Claims closed during the year; and,
3. Claims closed in prior years but which have some form of post-closure activity, such as a new claim payment or new reserve posting.

Exposure: The term "exposure" generally means the number of months of coverage provided to a single health care provider. Often a policy will insure more than one health care provider. For purposes of "number of person months" of exposure for a medical professional, multiply each provider covered by the number of months that coverage was provided in the data year in question. For example, a single-doctor policy with an inception date of July 1 would reflect 6 months of exposure for that particular year. Facilities may use different exposure base, such as number of beds or outpatient visits.

Individual insurance policies frequently cover both primary health care providers in their practices and individuals such as nurses, technicians, etc. For purposes of this data call, exposures should be reported separately for the various provider types by ISO specialty codes. A year of coverage for a general practitioner in solo practice with a single full-time nurse would be reported as 12 months of G.P. exposure and 12 months of nurse exposure, using the appropriate ISO codes. However, if the premium associated with the individual provider specialty types cannot be meaningfully allocated to each individual provider type, the entire premium should be reported for the primary health care provider. In our example, the entire premium would then be reported under the G.P. but not the nurse.

Health Care Stabilization Fund Feasibility Board: The HCSFFB was created by Missouri House Bill No. 1837 in 2006, in what became Section 383.250 of the Revised Statutes of Missouri. The HCSFFB was given the charge "…to determine whether a health care stabilization fund should be established in Missouri to provide excess medical malpractice insurance coverage for health care providers." Consisting of the Missouri Director of Insurance, two state Senators, two state Representatives and five members appointed by the Director of DIFP, the Board is directed to analyze whatever medical malpractice insurance data it deems necessary to accomplish its mission.

IBNR Reserves: See definition above for "Bulk Reserves."

Incidents: An "incident" is a medical misadventure that has not yet become a formal claim as defined above. Some medical malpractice insurance policies request insured health care providers to report any possible cases of malpractice, even if no one has yet demanded any damages for that malpractice. Do ***not*** report such incidents until they have matured into claim as defined above.

Indemnity Payment: The amount paid under an insurance policy in settlement of or in satisfaction in whole or in part of a claim or a judgment against an insured.

ISO: Insurance Services Office, Inc., an insurance industry advisory organization. In a number of instances, this data call relies on classification systems developed by ISO for the medical malpractice insurance industry. The classification codes and related information and materials are owned by, copyrighted by, and proprietary to Insurance Services Office, Inc. ("ISO"). They are being used here with the consent of ISO for the sole purpose of maintaining consistency in the gathering of the data requested. The ISO material is not to be used for any other purposes without the express written consent of ISO. Any questions concerning their use as part of this data call should be directed to the Missouri Department at Statistics@insurance.mo.gov. ***Do not contact ISO with questions about this data call.***

Example of the Aggregation Process

The information reported for this data call should be aggregated for Data Set #s 1, 2, and 3. The information reported in Data Set #4 is reported on a claim-by-claim basis.

For Data Set #s 1, 2, and 3, information should be aggregated for those policies sharing a complete set of characteristics in common (i.e., the shaded columns). The example below illustrates this process.

> **Example:** Assume ABC Insurance Company (NAIC Code 12345) writes coverage for five new doctors in St. Louis County, Missouri, beginning at the start of 2002, three of whom are family physicians (ISO Specialty Code 80420) and two of whom are pediatricians (ISO Specialty Code 80267). All are in solo practice covered under individual claims-made policies for the year. To simplify the example, assume the policies share the same policy characteristics, such as occurrence limit, annual limit, and deductible. The basic raw information on these five providers for Data Set #1, *before* aggregation, might look something like the following

Data Set #1 Information *Before* Aggregation

NAIC_Co_Code	Co_Name	Data_Year	Subline_Code	Policy_Type	Occurrence_Lmt	Annual_Limit	Deductible	Claims_Made_Year	ISO_Specialty	FIPS_County_Code	Direct_Written_Prem	Direct_Written_ Exposure (in Months)	Written_Assessments	Direct_Earned_Prem	Direct_Earned_ Exposure (in Months)
ABC	12345	2002	235	20	$X,000	$Y,000	$Z,000	1	80420	189	$10,100	12	0	$10, 100	12
ABC	12345	2002	235	20	$X,000	$Y,000	$Z,000	1	80420	189	$20,200	12	0	$20,200	12
ABC	12345	2002	235	20	$X,000	$Y,000	$Z,000	1	80420	189	$30,300	12	0	$30,300	12
ABC	12345	2002	235	20	$X,000	$Y,000	$Z,000	1	80267	189	$5,000	12	0	$5,000	12
ABC	12345	2002	235	20	$X,000	$Y,000	$Z,000	1	80267	189	$6,000	12	0	$6,000	12

After aggregation, the five data rows above are collapsed into the two data rows on the following page, because the five policies in questions share all the same data category characteristics *except* ISO Specialty codes, of which there are two. Therefore, these five data rows can be combined into two aggregated data rows, with the numerical information in the "data element" columns (i.e., the unshaded columns) being added together (or aggregated) for those rows that share all the same basic information and data category characteristics. The result would look like this:

Data Set #1 Information *After* Aggregation

NAIC_Co_Code	Co_Name	Data_Year	DIFP_Subline	Policy_Type	Occurrence_Lmt	Annua_Limit	Deductible	Claims_Made_Year	ISO_Specialty	FIPS_County_Code	Direct_Written_Prem	Direct_Written_ Exposure (in Months)	Written_Assessments	Direct_Earned_Prem	Direct_Earned_ Exposure (in Months)
ABC	12345	2002	235	20	$X,000	$Y,000	$Z,000	1	80420	189	$60, 600	36	0	$60, 600	36
ABC	12345	2002	235	20	$X,000	$Y,000	$Z,000	1	80267	189	$11,000	24	0	$11,000	24

A similar aggregation process should be followed for Data Set #s 2 and 3. Data Set #3, which captures information on reserves, is highly aggregated in the sense that there are only three data categories used in the sorting process, those being subline code, policy type and accident or report year. The insurers should report the case basis loss reserve and case basis ALAE reserves at year end for each claim.

Data Set #3 also requires the reporting insurer to provide "basic limits" case basis loss reserves. The procedure for calculating the basic limits values is simple, with one special case applicable to policy limits shared among multiple practitioners involved in a malpractice case. Since the point of the basic limits analysis is to determine whether a hypothetical stabilization fund would be exposed to excess coverage liability, we need to determine whether a claim's case basis reserve amount exceeds the $300,000 attachment point selected for our hypothetical excess coverage. If the case basis reserve amount is less than $300,000, then that same dollar amount is then entered in the claim's corresponding basic limits cell. If on the other hand the claim value of case basis reserve amount is equal to or greater than $300,000, then payments are capped at $300,000. The $300,000 level is an absolute cap, and not an annual one. Once the reserve amounts surpass $300,000 the basic limit variables are capped at this amount for each subsequent year the claim is reported. While the HCSFFB will also be interested in a "basic limits" analysis on indemnity payments in addition to case bases loss reserves, DIFP will be able to perform that analysis from information provided in Data Set #4.

Data Set #4 Data Set #4 is a claim-by-claim report, and is therefore not aggregated as are Data Sets #s 1, 2 and 3. Insurers should *not* aggregate the information for the unshaded data element cells by common shaded basic element cells and data category cells, as described in the example above. They should still report the information for the basic information, data category and data element cells, but for each separate observation for Data Set #4. The data element information captured by Data Set #4 relates to indemnity payments and ALAE payments made on a claim in a year. Since it is possible that multiple payments might be made in a year, the reporting insurer should add up these amounts and report the annual totals. For years in which a claim is open but there is no payment activity in the indemnity or ALAE payment categories, insurers should enter a zero ("0"0 to allow DIFP to know the claim is still open.

Special Rule Regarding "Shared Limits" and "Basic Limits" Values: In some cases, a medical malpractice insurance policy may provide coverage to several different insureds in which all insureds share the policy's limits of liability. In such cases, where more than one insured is found liable under such a policy, it is the *sum* of the liabilities of the insureds that determines whether or not the maximum coverage on the policy has been exceeded.

Under this data call, it is assumed that a stabilization fund would only be responsible to the degree that the sum of such shared-limits liabilities exceeded $300,000. For example, assume a reserve of $100,000 was established for a doctor under such a shared-limits policy, and the corresponding reserve for his professional corporation insured under the same policy and with shared limits of liability was $250,000. Neither amount by itself would exceed the $300,000 cap for the basic limits analysis described above for a "typical" policy, but if a shared limits policy were in place, the combined reserve for the two coverages of $350,000 *would* exceed the $300,000 threshold. In such a case, the reporting insurer will be required to report the relative share of the $300,000 cap represented by each claim.

In the example discussed above, the doctor is allocated a share of the total reserve of $350,000 is equal to 28.6% (or $100,000 divided by $350,000), while the corporation's share of the reserve is equal to 71.4% (or $250,000 divided by $350,000). (Note, the separate individual percentages should add up to 100%.) These two percentages would then be used to calculate the *Basic Limits* values to be reported for the shared limits claims. Each claim is allocated an amount equal to $300,000 multiplied by that claim's relative percentage of the total. In our example, the *Basic Limits Reserve* for the doctor would be $85,800 (or $300,000 x 28.6%) and the amount for the corporation would be $214,200 (or $300,000 x 71.4%) or $214,200, and the two amounts should add up to $300,000.

Reopened Claims

Reopened claims should be assigned the same claim and occurrence identifiers as the original claim. Such claims will be identified by the reopened year. If a claim is open and closed multiple times, assign a new reopen year to each instance the claim is reopened.

Variable Definitions

Note: The "format" employed for the variable names used in the HCSFFB Data Call is designed to meet the naming conventions of the SAS statistical software package the Department will be using to analyze the data. These variables are listed below in alphabetical order according to the SAS-ready version of the name, followed by a non-technical version of the name set forth in parentheses.

Accident_or_Report_Year (Accident or Report Year) The information reported in this data category will depend on whether the claim in question is associated with an "occurrence" policy or another type of policy. If it is an occurrence policy, report the relevant "accident year," that being the year in which the alleged injury occurred. Where the alleged injury is the result of a series of related events, provide the year that triggered coverage under the policy or policies. If the policy is of a policy type other than an "occurrence" policy (such as a claims-made policy), report the "report year, that being the year a claim is first reported under the terms of the policy. For example, some policies require an insured health care provider to report possible incidents of malpractice that have occurred, even though no formal claim for damages has been filed; these policies tend to consider such incident reports as a trigger for coverage if a formal claim is later made or an indemnity payment is made, so that the year of this incident report would be the "report year" for purposes of this data category.

ALAE_Paid (Allocated Loss Adjustment Expense Paid) Defense and other expenses related to adjudicating a claim paid out during the data year. Exclude unallocated or overhead expenses that are not directly tied to a claim. Amounts reported should reconcile with the financial annual statement.

Annual_Limit (Annual Limit) Specify the annual limit of liability stated in the policy in $1,000 increments.

BLCBLRes (Basic Limits Case Basis Loss Reserves) The indemnity reserve on an individual claim posted by the reporting insurer's claims adjusters, evaluated as of the end of the data year in question but capped so as not to exceed the $300,000 basic limits threshold. Exclude allocated loss adjustment expense (ALAE) payments or bulk or IBNR reserves. Report estimated unpaid amounts and do not include partial payments already made. To be entered in responses to Data Set # 4.

CBALAERes (Case Basis Allocated Loss Adjustment Expense Reserve) The ALAE reserves on an individual claim posted by the reporting insurer's claims adjusters, evaluated as of the end of the data year in question. Exclude bulk or IBNR reserves. Report estimated unpaid amounts and do not include partial payments already made. To be entered in responses to Data Set # 3 or #5.

CBLRes (Case Basis Loss Reserves, Claims) The indemnity reserve on an individual claim posted by the reporting insurer's claims adjusters, evaluated as of the end of the data year in question. Exclude bulk or IBNR reserves. Report estimated unpaid amounts and do not include partial payments already made. To be entered in responses to Data Set # 3.

Claim_Identifier (Claim Identifier) For Data Set #4, report the claim number or other unique alphanumeric identifier used to distinguish one claim from other claims.

Claims_Made_Year (Claims Made Year) The year of entry into claims made coverage, capped at 5 as follows:

Claims Made Year (Not Policy Type 10 or 11)	
1	1st Year Claims Made
2	2nd Year Claims Made
3	3rd Year Claims Made
4	4th Year Claims Made
5	5th or Later Year Claims Made

Co_Cancelled (Company Cancelled) For the data year in question, report the number of policies for which the *insurer* elected to cancel the coverage for circumstances allowed under the "cancellation" clause of the policy. Includes all company-initiated cancellations of the policies where the cancellation's effective date is during the data year in question. Do *not* include policies cancelled for non-payment of premium, cancelled at the insured's request, or cancelled for 're-write' purposes where there is no lapse in coverage. The number of cancellations should be reported on a "policy" basis regardless of the number of insureds or locations covered under the policy.

Co_Name (Company Name) Companies do not need to report their full legal name, so long as reporting is consistent throughout the data call.

Co_Norenewed (Company Nonrenewed) Report the number of policies for which the *insurer* elected not to renew the coverage for circumstances allowed under the "nonrenewal" clause of the policy. Includes all company-initiated nonrenewals of the policies where the nonrenewal effective date is during the data year in question. Exclude policies where a renewal offer was made and the policyholder did not accept the offer, or where the policyholder requested that the policy not be renewed. The number of nonrenewals by company should be reported on a "policy" basis regardless of the number of insureds or locations covered under the policy.

Data_Year (Data Year) Each calendar year between 1997 and 2008. A data year represents the financial, policy or claims activity occurring between January 1 and December 31 to be reported under Data Sets #s 1, 2, 3 and 4.

Deductible (Deductible) The deductible amount reporting in $1,000 increments. Enter zero ("0") for policies without a deductible.

DILP (Direct Indemnity Losses Paid) The total amount of direct indemnity losses paid in the data year.

Direct_Earned_Exp (Direct Earned Exposure) Direct Earned Exposures corresponding to the premium dollars for the Missouri coverage provided during a data year. Most often, exposures for individual insured health care providers or groups of providers are expressed in terms of months of coverage. A list of ISO codes and exposures is available on the DIFP web site at:

http://insurance.mo.gov/private/medmalindex.htm

Direct_Earned_Prem (Direct Earned Premium) The dollar amount of premium earned during a data year. Amounts should reconcile with the Financial Annual Statement as per item number 16 in the accompanying Questionnaire at page 29. If the reconciliation totals deviate by more than 5%, please provide an explanation to the Statistics Staff of DIFP in the space provided on the Questionnaire

For informational purposes, a definition of Direct Earned Premium is: The dollar amount of premiums associated with those portions of policy terms as of December 31 of the calendar year in question for Missouri medical malpractice coverage, determined in the same manner as used for the NAIC annual statement. Direct earned premium shall include any policy or membership fees, less return premiums and premiums on policies not taken, without any adjustments for ceding or assuming any portion of such premium to or from any reinsurers.

Direct_Written_Exp (Direct Written Exposure) The number of exposures written during a data year. Most often, exposures for individual insured health care providers or groups of providers are expressed as months of coverage. A list of the ISO codes and exposures is available on the DIFP web site at;http://insurance.mo.gov/private/medmalindex.htm . The number of exposures corresponds to the Direct Written Premium for the data year in question.

Direct_Written_Prem (Direct Written Premium) The dollar amount of premium written during a data year. Amounts should reconcile with the Financial Annual Statement, as per item number 16 in the Questionnaire at page 30. If the total deviates by more than 5% for a given year, please provide an explanation on the questionnaire.

For informational purposes, the definition of Direct Written Premium is: Gross premiums received for Missouri medical malpractice coverage written for a given calendar year, determined in the same manner as used for the NAIC Annual Statement. Direct written premium shall include any policy or membership fees, less return premiums and premiums on policies not taken, without any adjustments for ceding or assuming any portion of such premium to or from any reinsurers.

FIPS_County_Code (FIPS County Code) The three-digit County Federal Information Processing Standards (FIPS) code for the Missouri County in question. The county to report for a particular policy under the data call is the most appropriate county for purposes of the insurance company's territorial rating and underwriting of that policy.

FIPS Co. Code	Missouri County Name	FIPS Co. Code	Missouri County Name	FIPS Co. Code	Missouri County Name	FIPS Co. Code	Missouri County Name
001	Adair	059	Dallas	117	Livingston	175	Randolph
003	Andrew	061	Daviess	119	McDonald	177	Ray
005	Atchison	063	DeKalb	121	Macon	179	Reynolds
007	Audrain	065	Dent	123	Madison	181	Ripley
009	Barry	067	Douglas	125	Maries	183	St. Charles

011	**Barton**	**069**	**Dunklin**	**127**	**Marion**	**185**	**St. Clair**
013	**Bates**	**071**	**Franklin**	**129**	**Mercer**	**186**	**Ste. Genevieve**
015	**Benton**	**073**	**Gasconade**	**131**	**Miller**	**187**	**St. Francois**
017	**Bollinger**	**075**	**Gentry**	**133**	**Mississippi**	**189**	**St. Louis**
019	**Boone**	**077**	**Greene**	**135**	**Moniteau**	**195**	**Saline**
021	**Buchanan**	**079**	**Grundy**	**137**	**Monroe**	**197**	**Schuyler**
023	**Butler**	**081**	**Harrison**	**139**	**Montgomery**	**199**	**Scotland**
025	**Caldwell**	**083**	**Henry**	**141**	**Morgan**	**201**	**Scott**
027	**Callaway**	**085**	**Hickory**	**143**	**New Madrid**	**203**	**Shannon**
029	**Camden**	**087**	**Holt**	**145**	**Newton**	**205**	**Shelby**
031	**Cape Girardeau**	**089**	**Howard**	**147**	**Nodaway**	**207**	**Stoddard**
033	**Carroll**	**091**	**Howell**	**149**	**Oregon**	**209**	**Stone**
035	**Carter**	**093**	**Iron**	**151**	**Osage**	**211**	**Sullivan**
037	**Cass**	**095**	**Jackson**	**153**	**Ozark**	**213**	**Taney**
039	**Cedar**	**097**	**Jasper**	**155**	**Pemiscot**	**215**	**Texas**
041	**Chariton**	**099**	**Jefferson**	**157**	**Perry**	**217**	**Vernon**
043	**Christian**	**101**	**Johnson**	**159**	**Pettis**	**219**	**Warren**
045	**Clark**	**103**	**Knox**	**161**	**Phelps**	**221**	**Washington**
047	**Clay**	**105**	**Laclede**	**163**	**Pike**	**223**	**Wayne**
049	**Clinton**	**107**	**Lafayette**	**165**	**Platte**	**225**	**Webster**
051	**Cole**	**109**	**Lawrence**	**167**	**Polk**	**227**	**Worth**
053	**Cooper**	**111**	**Lewis**	**169**	**Pulaski**	**229**	**Wright**
055	**Crawford**	**113**	**Lincoln**	**171**	**Putnam**		
057	**Dade**	**115**	**Linn**	**173**	**Ralls**	**510**	**St. Louis City**

Insured_Cancelled (Insured Cancelled) The number of policies for which the *insured* elected to cancel the coverage. Includes all policyholder-initiated cancellations where the cancellation's effective date is during the data year in question. *Include policies cancelled for non-payment of premium.* Cancellations should be reported on a policy basis regardless of the number of insureds or locations covered under the policy.

Insured_Nonrenewed (Insured Nonrenewed) The number of policies for which the *insured* effectively elected not to renew the policy. Includes policies where a renewal offer was made and the policyholder did not accept the offer, or where the policyholder requested that the policy not be renewed. Includes non-renewals for non-payment of premium. The number of nonrenewals by insureds should be reported on a "policy" basis regardless of the number of insureds or locations covered under the policy.

ISO_Specialty (ISO Specialty) The 5-digit ISO Classification Code for the health care provider(s) of entities insured. The code numbers are provided on the Department's web site at http://insurance.mo.gov/private/medmalindex.htm . The classification codes and related information and materials are owned by, copyrighted by, and proprietary to Insurance Services Office, Inc.

("ISO"). They are being used here with the consent of ISO for the sole purpose of maintaining consistency in the gathering of the data requested. The ISO material is not to be used for any other purposes without the express written consent of ISO. Any questions concerning their use as part of this data call should be directed to the Missouri Department at: Statistics@insurance.mo.gov.

Insurers who have used the ISO specialty codes in the past as the basis for their rating of coverage may use the codes assigned for the data year in question, regardless of whether ISO has subsequently modified those code number assignments or definitions. On the other hand, insurers who are converting their past internal specialty coding system to the ISO basis for purposes of this data call should use the current ISO codes, as provided on the DIFP web site.

Mass_Tort (Mass Tort) Indicate "mass tort" actions, such as a class action products liability suits, by entering an "M". The "mass tort" indicator is included because lawsuits such as class action cases have a tendency to list numerous individual health care providers as defendants, often with no ultimate indemnity payments against them. The "mass tort" designation" will help the Department explain any "peaks" in the claim data due to such situations. A question in the accompanying Questionnaire asks the reporting insurer for additional details on their experience with such cases.

NAIC_Co_Code (NAIC Company Code) The 5-digit identification number assigned by the National Association of Insurance Commissioners (NAIC). Those insurers that are part of a holding company group of companies may have an additional 4-digit number that identifies this holding company group and which is often written before the 5-digit company code. For purposes of this data call, reporting insurers should use only the 5-digit NAIC company identification number.

Newly_Written (Newly Written) The number of newly-written policies where the effective date is during the data year in question. Do not include 'rewritten' or reinstated policies unless there was a lapse in coverage.

Occurrence_Identifier (Occurrence Identifier) An occurrence is defined as a medical malpractice event or series of malpractice events leading to one or more claims under a given medical malpractice insurance policy.

The "occurrence identifier" can be any unique set of alphanumeric characters used to distinguish one "occurrence" from another.

For example, where there are two doctors who are part of the same group practice, who are insured under the same group policy and who are individually sued by the same injured party for the same malpractice event, the reporting insurer who covers them should report two "claim indentifiers" for the separate claims but the same, common "occurrence identifier," to be supplied in the appropriate field for each of the two claims.

Occurrence_Limit (Occurrence Limit) Specify the per-occurrence limit of liability specified in the policy in $1,000 increments.

Policy_Type (Policy Type) Use the following code numbers to identify the type of policy in question.

Note: For deductible policies, the insurer is liable for losses but seeks reimbursement for the deductible from the policyholder. Record deductible policies as basic. For excess policies, the insurer is not liable for losses below the retention.		
Basic	**Excess**	**Type**
10	11	Occurrence
20	21	All other types of policies, including Claims-Made, Extended Reporting Period (Tail Policy or DDR Policy) Prior Acts Coverage (if written as a separate policy)

Policy_Year (Policy Year) The calendar year in which the policy became effective.

Renewed (Renewed) The number of policies renewed during the data year in question. Do not include 'rewritten' policies where there is a lapse in coverage. Where there is such a lapse, consider the post-lapse policy to be a "Newly_Written" policy and report it accordingly (see definition above). Generally, a change in coverage under a policy from one year to the next is considered a renewal rather than a new policy.

Reopened_Year: (Reopened Year) A data category that is used for Data Set #4 to indicate that a previously-closed claim has been reopened. The data cells for this variable name for claims reported under Data Set #4 that have *not* been reopened should be left blank; cells for those claims that have closed and then been reopened should be filled in with the data year in which they are reopened.

Status_Year_End (Status at Year-End) Claim status indicator, equal to

O – Open
CWIP – Closed With Indemnity Payment
CWOIP – Closed Without Indemnity Payment

Subline_Code (Subline Code) The subline code is used to broadly identify the type of entity being insured, be it a hospital, another type of facility, or a solo or group practice. ISO has developed two sets of subline codes, one relating to "simplified" policies (which also cover employees) and the other relating to policies that are not "simplified." The ISO subline code numbers are set forth in the left-most column of the chart below.

For purposes of this data call, the data are to be further subdivided beyond the ISO sublines to distinguish between those policies where the primary insureds are covered by individual limits of liability and those policies where the primary insureds are covered by shared limits of liability. The term "primary insureds" refers to the main physicians, surgeons or other professionals covered under the policy, as opposed to their nurses, technicians or their professional corporations.

The majority of coverage is written with separate limits of liability for the primary insureds, even where coverage is labeled "group" coverage. Most solo practices and those "group" policies with

separate limits of liability for the primary insureds should be given the new subline code numbers 236 (for physicians and surgeons) and 246 (for other health care professionals). For insurers using the ISO subline code numbers, solo practices and group practices with separate limits of liability that have been assigned ISO code numbers 235 and 245 will need to be converted to the new numbers 236 and 246. In addition, the new subline codes 237 and 247 designate the relatively rare cases where the primary insured health care providers have *shared* limits of liability.

The remaining subline codes are used in conformity with ISO definitions. These subline codes and related information and materials are owned by, copyrighted by, and proprietary to Insurance Services Office, Inc. ("ISO"). They are being used here with the consent of ISO for the sole purpose of maintaining consistency in the gathering of the data requested. The ISO material is not to be used for any other purposes without the express written consent of ISO. Any questions concerning their use as part of this data call should be directed to the Missouri Department at Statistics@insurance.mo.gov.

Standard ISO Subline Codes Simplified Policies / (Not Simplified Policies)	***New* Data Call Subline Codes** **(In Bold)**	Description
215 / (210)	215 (or 210)	Hospital Professional Liability (including physicians, surgeons, dentists and other health care professionals insured as employees under a Hospital policy)
225 / (220)	225 (or 220)	Other Health Care Facilities Liability (including physicians, surgeons, dentists insured as employees under a Blood Bank, Diagnostics Testing Laboratory Policy or other health care facilities liability policy).
235 / (230)	**236**	Physicians and Surgeons Solo or Group Professional Liability Coverage with **Individual Limits of Liability** (**not** insured as employees under a Hospital, Blood Bank, Diagnostics Testing Laboratory Policy).
235 / (230)	**237**	Physicians and Surgeons Group Professional Liability Coverage with **Shared Limits of Liability** (**not** insured as employees under a Hospital, Blood Bank, Diagnostics Testing Laboratory Policy or other health care facilities liability policy).
245 / (240)	**246**	Other Health Care Professional Solo or Group Liability Coverage with **Individual Limits of Liability** (**not** insured as a group practice and **not** insured as employees under a Hospital, Blood Bank, Diagnostics Testing Laboratory Policy)
245 /(240)	**247**	Other Health Care Professional Group Liability Coverage **with Shared Limits of Liability** (**not** insured as employees under a Hospital, Blood Bank, Diagnostics Testing Laboratory Policy)
275 / 270	275 (or 270)	All Composite Rated Risks
285 / (280)	285 (or 280)	Indivisible Premium Policy Experience (policies for which at least one-half of the premium is for medical professional liability insurance)
	9nnn**	Used to report experience for programs or segments that are incongruent with the other sublines. Used only with prior permission of DIFP.

Written_Assessments (Written Assessments) Assessments that were levied (including declared but uncollected) in excess of premium collected during the year ending 12/31/yyyy.

HCSFFB Data Call Questionnaire

A completed questionnaire should accompany each insurer's data submission.

Filing Information

Please provide the relevant contact information in the spaces provided below.

Company Name:

Company Contact Person's **Name:**

Job Title:

Email Address:

Telephone Number:

Mailing Address:

Formatting Information

Please explain any unique formatting issues are associated with the data. For example, if the data are being provided in a number of discrete sub-units (such as, say, separate files for each Data Year), please identify the separate units and explain how they fit together. If the data have been encrypted, please indicate how to undo the encryption.

Supplemental Narratives and Reconciliations

Please provide written comments on to the following items. Include in your comments: (a) a *detailed* narrative response to each question posed or explanation being sought; (b) indicate the magnitude of any problem you have identified in the narrative and also estimate the resulting impact on the usefulness of the data for actuarial purposes; and, (c) provide supplemental or supporting data if necessary.

A downloadable version of the Questionnaire is available on the Department's web site at: http://insurance.mo.gov/private/medmalindex.htm; please use it as a template for your submission. Include your narrative responses after each separate item, taking as much additional space as necessary. Identify any supplemental data by file name in the questionnaire response and include each such data file as an attachment.

1. Were there any instances in which the instructions could not be complied with or estimates were made?

2. Does your Company's data include any information regarding any insurers who once operated as separate entities but were later absorbed via a merger or similar transaction? If so, does the prior entity's data depart from the standards of the data call?

3. In the context of changes to the definition of ALAE on the financial annual statement, explain how this data element was defined in each of the data years of the data call.

4. Reopened claims should ***not*** be treated as separate claim distinct from the original claim. Were there any departures from this standard?

5. As to "ancillary *corporate* exposures" associated with solo and group policies covering physicians & surgeons, and solo and group policies covering other medical professionals (identified by new subline codes 236, 237, 246, and 247, as defined for use in this data call):

    a. Indicate whether policy limits apply to the ancillary corporate exposures on an individual limits basis or a shared limits basis. If coverage is provided on *both* an individual limits and shared limits basis, what are the approximate proportions?

    b. Describe the way corporate exposures, premiums, claim counts, losses and ALAE are reported.

6. As to "ancillary exposures *of employees*" associated with solo and group policies covering physicians & surgeons, and solo and group policies covering other medical professionals (identified by new subline codes 236, 237, 246, and 247, as defined for use in this data call):

    a. Indicate whether policy limits apply to the ancillary employed medical professionals such as nurses on an individual limits basis or a shared limits basis. If coverage is provided on *both* an individual limits and shared limits basis, what are the approximate proportions?

    b. Describe the way corporate exposures, premiums, claim counts, losses and ALAE are reported.

7. Describe any departures from reporting standards specific to tail and DDR premiums, claim counts, losses and expenses.

8. For any occurrence policies issued by your company, would it be possible under the policy language for multiple limits of liability to be awarded for multiple policy years? For example, could injuries occurring in multiple policy periods be treated as a distinct occurrence or does policy language preclude such a possibility?

9. Does your Company track related claims filed by a single party against multiple insureds (sometimes referred to as "occurrences")? For example, is the Company's system able to identify as an "occurrence" situations where two insured doctors are sued for the same malpractice event or related series of malpractice events?

10. Does the Company's response to the data call include claims associated mass tort or product liability cases, such as those involving Fen-Phen, Vioxx, or breast implants? If so, please identify the particular mass tort cases in question and provide the number of reported claims, closed claims, paid losses, paid ALAE, and year-end case basis reserves for each calendar year.

11. During the experience period (1997 to 2008), did the Company make changes in reserving practices, legal defense of claims, or other aspects of claims administration that impact loss development? If so, please explain.

12. During the experience period (1997 to 2008), did the Company make significant changes in coverage due that impact loss development or trends? If so, please explain.

13. Please explain any other significant issues or problems with the Company's responses to the data call.

14. Data Set #3 is designed to collect information on case basis ALAE and indemnity loss reserves. Because the reserves for claims that are still open are viewed by insurers as highly sensitive, Data Set #3 is designed to be "highly aggregated," such that information on individual claims will likely be combined with many other similar claims, obscuring the specific details of the individual claims. However, whether Data Set #3 achieves this result will depend on a variety of factors, including the number and variety of an insurer's claims. If in responding to this data call an insurer realizes that sensitive research information is not being adequately protected, the insurer should contact the Department's statistics section at statistics@insurance.mo.gov to discuss possible alternative reporting procedures.

15. *Claim Count Reconciliations:* The Company's "total claims count" and "open claims count" for the various data years covered by the data call should closely approximate the total number of individual claims and open claims reflected in the individual reports that have already been submitted to the Department by the Company under the claim reporting requirements of Section 383.105, RSMo. Below, please provide these two sets of totals for the separate years covered by the data call. Thereafter, provide an explanation for any years where the totals for either set differ by more than 5%. Contact DIFP for information about medical malpractice claims from your company on file.

Year	Total Claims Closed [from Section 383.105, RSMo Reports]	Total Claims Closed [from HCSFFB Data Call]	Difference in Excess of 5% (if Any)	Total, Claims Open at Year End [from Section 383.105, RSMo Reports]	Total, Claims Open at Year End [from HCSFFB Data Call]	Difference in Excess of 5% (if Any)
1997						
1998						
1999						
2000						
2001						
2002						
2003						
2004						
2005						
2006						
2007						
2008						

Explanations, (if any):

16. *Additional Reconciliations:* Below are three reconciliation tables to be complete for each year of the data call (1997 through 2008) for which the reporting insurer was actively providing coverage or paying claims in Missouri. The reconciliations are designed to compare the reporting insurer's NAIC Annual Statement information for the Missouri Medical Malpractice page for Direct Written Premium, Direct Earned Premium and Direct Paid Indemnity Losses and ALAE Losses with the corresponding information contained in the insurer's responses to the data call. In addition to performing the reconciliations, the reporting insurer is asked to explain any differences in excess of 5% between the NAIC numbers and the data call numbers. *Since deviations of this magnitude could indicate significant underlying problems, reporting insurers should work to avoid such large deviations.*

    The Department's web site has a set of spreadsheet templates for the data call, with a separate sheet for Data Set #s 1, 2, 3, and 4 *and* a final sheet for the reconciliations under this Item 16 of the Questionnaire.

    The Department's spreadsheet templates can be accessed via:

    http://insurance.mo.gov/private/medmalindex.htm

Direct Written Premium and Direct Earned Premium Reconciliations

Year	(1) Direct Premiums Written [from Supplement A to Schedule T, Column 1*]	(2) Direct Written Premium [from Data Set #1]	(3) Written Premium Reconciliation [(2) minus (1) = (3)]	(4) Direct Premiums Earned [from Supplement A to Schedule T Column 2*]	(5) Direct Earned Premium [from Data Set #1]	(6) Earned Premium Reconciliation [(5) minus (4) = (6)]
1997						
1998						
1999						
2000						
2001						
2002						
2003						
2004						
2005						
2006						
2007						
2008						

*Designations refer to the numbering scheme for 2009. Prior years may differ.

Indemnity Losses Paid Reconciliation

Year	(1) Direct Indemnity Losses Paid (deducting salvage) [from State Page, Line 11, Column 5*]	(2) Direct Indemnity Losses Paid [from DILP, Data Set #4]	(3) Paid Indemnity Reconciliation [(2) – (1) = (3)]
1997			
1998			
1999			
2000			
2001			
2002			
2003			
2004			
2005			
2006			
2007			
2008			

*Designations refer to the numbering scheme for 2009. Prior years may differ.

ALAE Paid Reconciliation

Year	(1) ALAE (Defense Costs Paid) [from State Page, Line 11, Column 8*]	(2) ALAE_Paid [from Data Set #4]	(3) Paid ALAE Reconciliation [(2) – (1) = (3)]
1997			
1998			
1999			
2000			
2001			
2002			
2003			
2004			
2005			
2006			
2007			
2008			

*Designations refer to the numbering scheme for 2009. Prior years may differ.

Case Basis Reserve Reconciliation

Year	(1) Case Basis Reserves (Unpaid Losses) [from Supplement A to Schedule T, line 26, Column 6*]	(2) Reserves Posted as of the End of Data Year [from CBLRes, Data Set #3]	(3) Reserve Reconciliation [(2) – (1) = (3)]
1997			
1998			
1999			
2000			
2001			
2002			
2003			
2004			
2005			
2006			
2007			
2008			

*Designations refer to the numbering scheme for 2009. Prior years may differ